PROGRESS
OF
MEDICAL SCIENCE

SURGERY

UNDER THE CHARGE OF

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Trasplantation of the Ureters into the Large Intestine in the Absence of a Functionating Urinary Bladder.—COFFEY (*Surg., Gynec. and Obst.*, 1921, xxxii, 383) says that it was found in experimental work that the bile duct when implanted directly into a dog's small intestine always dilates, while a bile duct which has been transplanted and made to run immediately under the mucosa for a distance does not dilate. A ureter implanted directly into a dog's intestine always dilates and sooner or later the kidney is destroyed by pressure and infection. A ureter which has been transplanted and made to run immediately under the mucosa does not dilate as a rule. The author explains the dilatation universally found in direct implantation. The small intestine as well as the large is practically always found in a state of rotundity and partial distention, which he calls static intra-intestinal pressure. His second proposition was—how has Nature prevented this intra-abdominal pressure from reaching the inside of the normal duct? Dissection of the duodenum showed that the common duct passed through the wall of the intestine down to the mucosa and ran for a distance under the loose mucosa before emptying into the bowel. With a fountain syringe attached to a rubber bag and with a thin flap of rubber cemented over the inside of the tube's entrance, these same principles were demonstrated in a purely mechanical way. The modifications in technic and clinical application were devoloped by Charles H. Mayo.

Acute Intestinal Obstruction.—FINNEY (*Surg., Gynec. and Obst.*, 1921, xxxii, 402) says that early diagnosis is the most important factor. The shortness of the interval of time elapsing between the onset of the symptoms and the operation plays a most striking part. In 21 cases with operation within twelve hours from the beginning of symptoms, there were 20 recoveries and 1 death. The effect of the time element

can be still more strikingly seen in the steady increase of mortality with lengthened interval since the mortality of his entire series was 36 per cent. The author is impressed with the difficulty of definite diagnosis, for intestinal obstruction in many cases may be simulated by typhoid fever, Henoch's purpura, certain infections, appendicitis, acute pancreatitis, the twisted pedicle of a tumor, lead colic, renal colic, gallstones, mesenteric thrombosis, and diaphragmatic pleurisy. It is comforting to note, however, that most of these conditions demand operation almost as imperatively as bowel obstruction. Post-operative intestinal obstruction is often masked by the symptoms usually present in the first few days after operation. In cases of doubt it is safer to operate. The determining factors are the intestinal character of the vomitus, the failure of lavage and enemata to relieve the vomiting and an increasing pulse-rate with restlessness and thirst. The passage of the stomach tube in doubtful cases of this type may prove to be a means of avoiding reoperation if used with due intelligence. It is safe to say that approximately one-half of the cases of intestinal obstruction occurring in hospital and private practice have their origin in adhesions resulting from previous operative procedures. There has been no satisfactory explanation for some of the phenomena observed. It is probable that the two most potent factors are the presence of a persistent low grade inflammatory process, and the presence of some foreign body, such as unprotected gauze drains. Prevention of sepsis, careful handling of tissue and discontinuance of packing and repacking have helped much. Moreover, not much aid can be hoped for from artificial sources, such as the application to the peritoneal surfaces of ointments or membranes and the like. Paralytic adynamic ileus in some degree is probably of more common occurrence than is usually believed to be the case. Differential diagnosis between paralytic and mechanical obstruction is not always easy. These cases do not always look sick—abdominal pain is not marked, pulse rate is not much increased. Regurgitant vomiting is early pronounced but does not persist. After several days, in favorable cases, vomiting reappears—a sign of reëstablished gastro-intestinal activity. The pathology of this condition is still in doubt. The character of the anesthetic however, does not seem to play an important part, while infection is generally believed to be the most constant etiological factor but in the author's series the picture in a well developed case is rather that of a true paralysis of the sympathetic nervous system.

High Tracheotomy and Other Errors—The Chief Causes of Chronic Laryngeal Stenosis.—JACKSON (*Surg., Gynec. and Obst.*, 1921, xxxii, 392) says that the most frequent cause of chronic laryngeal stenosis is high tracheotomy. The classic distinction between a high and low tracheotomy with reference to the isthmus of the thyroid gland is a relic of the days when too much respect was held for this structure. This distinction should be abandoned. There should be taught only one tracheotomy and that should be low. The trachea should always be incised lower than the first ring, except in those rare cases in which laryngoptosis renders this impossible without entering the anterior mediastinum. The cricoid cartilage should never be cut, unless laryngoptosis places all the rings of the trachea below the upper

border of the manubrium. If, in an emergency, a high incision of the trachea has been made a cannula should not be worn in it. As soon as the patient's breathing has been resumed a low incision should be made and the cannula inserted therein.

Suprapubic Drainage of the Bladder.—MOTHERSILL AND MORSON (*Brit. Med. Jour.*, 1921, p. 418) state that acute retention of urine has been relieved by puncturing the bladder with trochar and cannula for a considerable period. More recently, a process has been refined to facilitate drainage and prevent any leakage into the prevesical space or upon the external abdominal wall. In certain suitable cases the insertion of the self-retaining tube invented by M. DePezzer fulfils its purpose of draining the bladder from above the pubes without leakage or discomfort. This method of drainage can only be adopted when a good distention is to be obtained and no previous operation has been performed. When hematuria is present, the operation is contra-indicated because the DePezzer tube is readily blocked by clots. So simple a procedure reduces shock, a most favorable factor in subjects requiring suprapubic drainage prior to prostatectomy because of deficient excretion of urea. The subsequent prostatectomy is without the difficulty caused by the scarring of the abdominal wall.

Treatment of Syphilis.—MACCORMAC AND KERMAWAY (*Brit. Med. Jour.*, 1921, p. 415) says that the syphilis is but one process whether it involves skin, mucous membrane, nerve or other tissue. The principles upon which treatment is based vary in accordance with the duration of infection. When infection is recent, primary or secondary, two objects are in view: cure of the disease and prevention of communication to others. A severe and lengthy course of treatment should be undertaken. The authors by extensive tabulation have shown that six injections of salvarsan, (Novarsenobenzol used) 0.9 gm. per dose are often insufficient. The "10 injections" series proved satisfactory. At conclusion of these salvarsan courses, mercury was administered intramuscularly for three months. The condition of the Wassermann reaction was determined. If positive, the course was repeated from the beginning. If negative Wassermann was obtained, mercury either in pills or by injections is continued until two years have been completed. The Wassermann reaction was investigated every three months. The authors admit that such a course is severe and long but justifiable when balanced with the serious results of failure and delaying of cure, for as time passes the disease becomes fixed. In late stages of disease active forms of medication such as salvarsan and mercury, by inunction and injection are preferable to other methods. Ten intravenous injections of salvarsan were given followed by three months of intramuscular mercury. Repetition of this course is generally necessary.

Renal Decapsulation for Chronic Nephritis.—KIDD (*Brit. Med. Jour.*, 1920, p. 378) reports several cases of far advanced chronic nephritis, where this procedure has given favorable results. The technic of the operation is described. He believes that the lymphatics are unblocked by decapsulation and that another route is set up for drainage of lymph from the kidney for the lymphatics of the kidney run up from the ureter under the capsule through the kidney where they receive